

AMNET NEWS

AMNET IS AN EASTERN COUNTIES, SELF-HELP GROUP OF FORMER AND NEW ACOUSTIC NEUROMA AND MENINGIOMA PATIENTS AND CARERS, BASED IN ADDENBROOKE'S HOSPITAL, CAMBRIDGE UK

Summer 2006
Issue 36

External Beam Radiotherapy for vestibular schwannoma and meningioma

A talk given by Kate Burton Advanced Practitioner in neuro-oncology and radiotherapy at Addenbrookes Hospital

Reported by Chris Richards



Ella Pybus introduced Kate to the meeting explaining that Kate had been involved in her treatment for a meningioma in 1999.

Kate introduced herself as a therapy radiographer and her role is to deliver treatment related to radiation. She specialises in the

treatment of patients with brain tumours and tumours of the spinal cord. Over the last few years there has been a huge increase in the number of acoustic neuroma patients being treated with radiotherapy at Addenbrookes Hospital.

Kate began with an intention to demystify radiotherapy. The history of radiotherapy goes back to 1885 when x-rays were first discovered and used as a treatment option and in 1899 there was the first reported cure due to radiotherapy. In 1922 radiation oncology was recognised as a medical discipline. By the 1950s radiotherapy had started to look as it does now with the use of linear accelerators which allow a much higher and better directed dose of x-ray radiation for treatment.

There are a number of myths associated with radiotherapy and Kate told us that the side effects are not as extreme as they used to be. In earlier treatments it was not known how much radiation

was required and dosage was measured in relation to the redness of the skin (erythema), but this has been found to be higher than is actually required to treat and the skin effects are far less now dosage is calculated more accurately. Radiotherapy can cause nausea and sickness but this is generally only when the stomach area is being irradiated.

Radiotherapy is using radiation to treat and in oncology this is usually to treat cancer, but radiotherapy is also used to treat benign tumours such as acoustic neuromas, meningiomas and pituitary tumours. These need to be treated because they occur in the skull which is a fixed size cavity. Even a small tumour can cause problems through pressure on the brain and tumours may be difficult to remove surgically because of their position close to important structures in the brain.

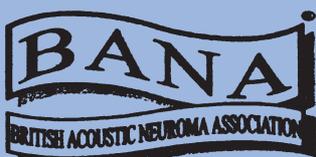
Radiotherapy works by damaging the DNA within the tumour cells and destroying their ability to reproduce. Tumour cells are normally radiation sensitive and die whereas normal cells are able to recover and repair themselves after radiation. Recent advances in medical imaging has resulted in lowering doses which means even less damage to normal cells.

The radiotherapy team consists of the oncologist, the medical specialist, the medical physicist who is responsible for ensuring the machines are working properly and that people receive the correct dosage of radiation, radiographers of whom there are about 50 in the department in Addenbrookes (many part-

Forthcoming meeting

The next meeting will be held on **Saturday 8th July** in the **Clinical School at Addenbrookes Hospital** from **10.30hrs**.

This will be the AGM of The British Acoustic Neuroma Association, of which we are corporate members and promises to be an exciting meeting with four speakers – more details inside. Everyone is welcome.



AMNET is a member Organisation of BANA, The British Acoustic Neuroma Association
AMNET is a registered Charity No. 1073908

time) and a similar number of oncology nurses who also give chemotherapy and palliative care support.

The term radiotherapy encompasses many different treatments. Radiotherapy can be given externally and this is known as **External Beam Treatment (EBRT)** when the beam is passed into the body from outside, or it can be given internally (**Brachytherapy**) when it can be placed into body cavities or inserted into the body using catheters. This approach is rarely used for brain tumours.

Radiotherapy can be given as a single treatment and this is known as radiosurgery **SRS** or as a number of treatments when it is known as fractionated. The machine used to deliver the radiotherapy is called a linear accelerator and it produces high energy x-ray photons which can be delivered in a very accurate way. The machine only produces radiation when it is actually switched on so there is little radiation hazard associated with these machines.

Fractionation is the dividing up of the radiation dose and the degree to which this is done depends on the type and size of the tumour, the location of the tumour and the surrounding normal tissue, and the treatment intent – whether this is radical or palliative. Brain tumours are normally treated with between 30 and 33 fractions which are given daily, five days a week, over six weeks. This dosage means there is a higher chance of the tumour cells being hit by the radiation when they are most vulnerable ie when they are dividing, and it also gives the normal cells a chance to recover between treatments, and a higher total dose can be given than in just a single treatment.

Recent advances now mean that they are able to use three dimensional conformal radiation therapy which allows a 3D picture of the tumour to be created and beams are precisely directed so as to avoid treating normal tissue as much as possible. **Intensity Modulated Radiation Therapy (IMRT)** is a specialised form of radiotherapy which allows the dose to be ‘shaped’ to the tumour. This is particularly good for tumours which are close to critical organs such as the spinal cord or very sensitive areas of the brain.

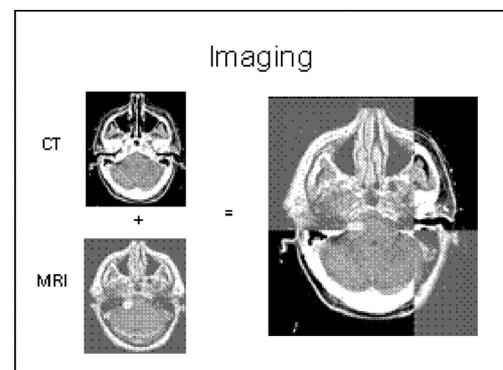
The Radiotherapy Pathway followed by patients includes firstly consultation with the oncologist, immobilisation, imaging and planning and then treatment.

Immobilisation is necessary as the patient is required to keep very still while treatment is carried out and they need to get back into exactly the same place each day so it is only the tumour which is treated. Immobilisation is ensured by using plastic shells or masks or stereotactic head frames. The plastic frames are made from a mould of the head taken using Plaster of Paris bandages. These are wrapped around the head leaving eyes, nose and mouth free and then allowed to set which takes 20 – 30 minutes. A mould of the head can then be made and a Perspex mask produced using this.

The stereotactic head frame can also be used and this has a mouth bite which is made using dental impression material and the frame holds the head still during treatment. Although producing these immobilisation instruments can be a little uncomfortable, staff try to make it as pleasant as possible and through all these processes patients can have a choice of music playing and often can have a friend or relative with them. See above.



Imaging involves getting a very detailed image of the tumour and two types of scan are used for this. The CT scan shows the density of bone and the brain tissue and also how much air is present in the brain. This allows the oncologist to work out the dose required based on what structures it will need to pass through and their density. However a CT scan cannot ‘see’ the tumour. Magnetic Resonance Imaging (MRI) shows the tumour but does not indicate any densities. The treatment can be planned using a computer programme which combines these two images so that the size of the tumour can be seen alongside the density of the structures surrounding it. This is a new technology which is not yet available in all centres. With these images the oncologist is able to ‘draw’ round the tumour on each slice of the MRI scan and the radiotherapy doses can be calculated to be directed on the tumour from a number of directions. The aim is to deliver an even, high dose to the target with minimal dosage to normal tissue and because this is fractionated then it is delivered in small enough doses that it will be tolerated by important structures such as the brain stem.



Treatment involves the patient being carefully positioned and immobilised. The ‘beams’ are only on for about a minute but the whole treatment session usually takes 20 – 25 minutes. Patients do not feel or see anything and will only hear the bleeping of the monitor. All treatments are computerised, the machines are carefully checked every

day and while treatment is being carried out patients are observed using close circuit TV.

Side effects will depend on the location of the tumour in the brain and whether it is close to any critical structures, the size of the treated volume of the tumour and the patients' general condition.



Side effects which may occur during the treatment period or immediately after are usually minimal and most patients can continue working through the treatment. They may experience tiredness and maybe a mild inflammation of treated skin. Hair loss only occurs in the treated area and normally is not permanent. There may be some nausea but this is usually controlled with medication. Later side effects some time after treatment may include an induced malignancy - the risk of this is thought to be about 1% for every 10 years of life after treatment. There may be a risk of dysfunction of the pituitary gland if this was included in the treatment area and a minimal risk of damage to nerves that are in the treated region such as hearing, balance and facial nerves - this risk is thought to be less than 1%. Toxicity does appear to be greater when treating patients who have vestibular schwannoma as a result of NF2.

Meningioma

The majority of meningiomas are benign and are graded from 1 - 3. Grade three is cancerous but this only accounts for 5% of meningiomas. They develop from the fibrous coating of the brain known as the meninges and are normally slow growing. They are primarily managed surgically which confirms the diagnosis and often results in complete excision so no further treatment is required.

The aim of radiotherapy is to stop the tumour growing bigger - it will not take it away but it will make it inactive and should stop any symptoms from getting worse. When deciding which patients should be offered radiotherapy there is a lack of evidence to show whether surgery or radiotherapy is a better treatment. It is suggested that radiotherapy should be offered to: all patients diagnosed with a grade 2 or grade 3 meningioma; where there is any tumour left following surgery and further surgery is not recommended; or in the case of tumours which come back after surgery.

Radiotherapy alone following radiological diagnosis may be offered for tumours which are surgically inaccessible because they are close to or involving critical structures and to patients with other medical problems who may not be suitable for surgery.

Outcome of meningiomas

With complete surgical excision 80% are still under control at 10 years and with subtotal excision and radiotherapy in benign tumours there is 80% control at 10 years. For radiotherapy alone there is a wide variation in reported outcome but it is suggested to be 50% at 10 years.

Vestibular Schwannoma

These are benign tumours which grow from cells lining the eighth cranial nerve. They are generally very slow growing and form about 8% of primary brain tumours. They can be diagnosed when they are very large or when they are very small.

Management

Management varies depending on the size of the tumour. It may be surveillance known as 'watch and wait', surgery or external beam radiotherapy. This radiotherapy may take the form of single treatment radiosurgery also known as Gamma knife in which the radiotherapy dose is given in one treatment or fractionated conformal stereotactically guided radiotherapy as described above.

Treatment Choice

| | Surgery | Radiotherapy (fractionated) |
|---------|--|--|
| For | Tumour completely removed in 97% cases Single event No follow up required | Minimal toxicity Retention of useful hearing Lack of long term morbidity |
| Against | Total hearing loss Morbidity and mortality Infection Rehabilitation may take months | Repeated hospital attendance Risk of induced malignancy Long term follow-up Salvage surgery may be required |

Evidence about hearing loss with radiotherapy is mixed. It may be reduced during therapy as the tumour tends to increase in size during treatment but then improves. There is some evidence that hearing levels may drop again later after 1-5 years.

Outcome

Reported outcomes for treatment of vestibular schwannoma treated with radiotherapy (Fuss et al 2000) suggest that there is 95% control at 5 years, that 46.5% of tumours show some shrinkage. There was useful hearing preservation in 85% of patients and 100% pre treatment normal facial nerve function was salvaged.

Kate answered questions from the floor and showed us examples of the immobilisation masks and headframes.

We would like to thank Kate for a very interesting and informative talk.

I would like to thank Steve West for this frank and interesting account of his journey towards making a decision about treatment. We hope the treatment is going well.

Making a decision about treatment of an acoustic neuroma

I am 43 years old and I am married with two children aged 10 and 13.

I was diagnosed with Acoustic Neuroma in the spring of 2005 following an MRI scan at my local Hospital in Stevenage. Prior to this I had been to see my GP regarding a loss of hearing which I initially put down to earwax and mild tinnitus in my left ear which I thought was due to medication I was taking for high blood pressure.

When I was shown what an Acoustic Neuroma looked like and what it was I was naturally disconcerted but I was quickly referred to Addenbrookes and went to see Mr Axon and Mr Burnet and discussed treatment options.

At the point when I was invited by Alison Frank to the AMNET meeting I had already gone through the very difficult process of choosing a treatment option which would be the best for my individual circumstances.

After several weeks of discussions at home and work, trawling the Internet and weighing up pros and cons of Surgery versus Radiotherapy, I had chosen to go for Surgery to remove the Neuroma.

My discussion at that time was based mainly on the unknown future outcomes of Radiotherapy, at 43 I consider myself to have a long future life ahead.

When I received Alison's call inviting me to the meeting I was very keen to go, I think I was trying to reassure myself that I would be able to cope with undergoing surgery and its after effects, which I had only read about up to this point.

It was very encouraging for both my wife and I to meet such a nice group of people and to realise that life does continue after surgery and that I am not alone when trying to come to terms with the effects of Acoustic Neuroma surgery.

I didn't fully realise until I arrived at Addenbrookes for the meeting on the 8th April 2006, who the speaker would be. When I started listening to Kate Burton from the Oncology Department at Addenbrookes, give a very informative and positive talk about Radiotherapy

treatment, something started ringing alarm bells inside me as to whether or not I had made the right decision.

For so long I had been focusing on the negative aspects of having treatment for Acoustic Neuroma and worrying about what may (or equally may not) happen in the long term after Radiotherapy. Kate's talk really made me focus on the positive aspects of Radiotherapy and look upon it as 'a state of the art' way of controlling the growth of the Neuroma.

It would also put an end to my deep down fears about the after effects of surgery (which could possibly have been made worse due to high blood pressure).

An added bonus would be the retention of my auditory nerve. Although I can not hear much on my left side, something is better than nothing.

I was scheduled to have surgery to remove my Acoustic Neuroma on 21st May 2006. So with some trepidation I contacted both Kate Burton and Jean Hatchell at Addenbrookes to say that I was having second thoughts about my decision. Both ladies were very helpful and patient. Both offered very good advice and support. No one was cross (except me) with my indecisiveness.

Kate very kindly arranged a meeting with Mr Burnet and I prepared a list of further questions regarding the Radiotherapy treatment.

Following my meeting with Mr Burnet on 21st April 2006, I finally made the decision to opt for Radiotherapy treatment instead of surgery.

Since then I have been absolutely amazed at the speed and efficiency of all the departments at Addenbrookes. Within days of saying yes, my wife received a call from Kate with all the appointment dates for all the various preliminary procedures required for Fractionated Stereotactic Radiotherapy which is expected to start on 23rd May 2006.

Having finally come to a decision, I can now get on with enjoying my life again and look forward to a time in the future when medical treatment for Acoustic Neuroma can alleviate difficult choices over treatments.

Meningioma Association UK

Here is a further update on the availability of specific drugs for people with fast growing brain tumours. While many of us have not been in this situation I think it does no harm to be aware of some of the political issues around the treatment of brain tumours in this country

NICE proposal denies hundreds of brain tumour patients chance to improved survival

A decision by the National Institute for Health and Clinical Excellence (NICE) regarding access to two groundbreaking brain tumour treatments has today (28 April) been met with disbelief, dismay and disappointment by patient and carer groups.

NICE has now confirmed that the chemotherapy drug **temozolomide (Temodal)**, used in the treatment of newly diagnosed high grade glioma, will only be available on the NHS in England and Wales on a severely restricted basis. **Gliadel Implants** have not been approved for use at all. Temozolomide, given at the same time as radiotherapy and for a time following, has been hailed as the biggest breakthrough in brain tumour treatment in 30 years. It is standard care in many European countries, the US, France, Canada, New Zealand and Australia.

Gliadel Implants are currently the only active treatment during the gap between neurosurgery and subsequent brain tumour treatment. The Implants have been formally appraised and approved for subsidized use in Scotland, the USA, Australia, France and Germany.

NICE has restricted the use of temozolomide to patients with a WHO performance rating of 0 (zero), ie those who appear to have nothing wrong with them. **Campaigners say they know of no other developed country which so severely restricts access on this basis.**

The highly restrictive decision on temozolomide means that roughly 900 patients not in the WHO=0 performance

status category will be ineligible. Roughly a similar number of all newly diagnosed high grade glioma patients will theoretically be denied the opportunity of accessing Gliadel Implants on the NHS regardless of their WHO score. A spokesperson for the brain tumour groups listed above said: "We feel hope has been dashed for hundreds of brain tumour patients. There are so few treatment options available for this utterly devastating disease that to deny so many UK brain tumour patients the chance of extended and meaningful survival by not allowing these therapies is hugely disappointing." She added: "NICE's decision directly contradicts the UK National Cancer Plan, which states that 'access to treatment will compare with the best in Europe.'"

The two therapies:

Temozolomide, also known as TEMODAL is already approved and subsidized in the USA, Canada, Australia, New Zealand and many European countries. In fact, the "concomitant therapy" of Temodal plus radiotherapy is being hailed as the biggest breakthrough in brain tumour treatment in nearly 30 years. It is now standard treatment for newly diagnosed high grade brain tumour patients in the above-mentioned countries.

GLIADEL Implants are already approved and subsidized in the USA, France, Germany, Scotland and Australia. Gliadel Implants allow immediate active treatment of the tumour whilst the patient is awaiting radiotherapy, meaning that the negative effect of the gap between surgery and radiotherapy is addressed.

FACTS & FIGURES

1860 - the number of people in England and Wales diagnosed with a malignant primary brain tumour each year.

36 - the number of leading UK consultants who wrote in February 2006 to Health Secretary Patricia Hewitt to object to NICE's brain tumour drugs rationing proposal.

112 - number of MPs who have signed two Early Day Motions on access to brain tumour treatments

Brain Tumour UK – SDRT – the IBTA Summer Conference
University of Nottingham Mon 3 to Tues 4 July 2006

Loose Cannons or Concerted Force: a way forward in the fight against brain tumours

New knowledge, new therapies, and a united approach to treating patients in a humane and respectful fashion

This is your conference!

This year, our Two Day Conference will be bigger and better than ever with stronger representation of brain tumour groups sharing this year's conference. The Samantha Dickson Research Trust, The International Brain Tumour Alliance and Brain Tumour UK have elected to host this year's conference in partnership, and to speak out together for brain tumour patients and carers everywhere.

For bookings & more information contact Jane Stephens on 0845 450 0386 or email jane.stephens@braintumouruk.org.uk
Bursaries will be available. (Programme to be confirmed)

postbag



We have some letters this time – the first is from BANA

Dear Alison

We would like to thank AMNET for the £50 sponsorship of Naomi Gaffney running the London Marathon. Naomi did complete the Marathon in 5 hours and 17 minutes and up to the 26th April she had raised £706.65 with your contribution and her employers also donated £500.

Your support is very greatly appreciated

Many thanks and best wishes

Julie Moore

BANA co-ordinator.

This is a letter from Nicky Leyland who came to our last meeting to find out more about AMNET

Dear Alison

Thank you very much for inviting me to your meeting last week at Addenbrookes. I found the time I spent with the AMNET group very informative, both from the talk on stereotactic treatment and from talking to some of your members. I'd like to thank you all for making me feel so welcome and I would certainly be interested in any future AMNET meetings

Yours sincerely

Nicola Leyland

Interesting Websites

Bells Palsy Information Site

<http://www.bellspalsy.ws/>

For those of you who do not know Bell's Palsy is a condition which often occurs spontaneously, without an obvious cause, producing paralysis of the facial nerve. Some of the information on this site is specific to people who have Bell's Palsy but as the symptoms are the same as those suffered by some acoustic neuroma and meningioma

patients following surgery, it may be of interest. The pages I found most interesting were on suggested exercises to assist recovery of movement in the facial muscles. There is advice and exercises for those newly diagnosed and also for people who have suffered paralysis and it's associated problems for a long time. One of the most interesting things for me was a very detailed diagram showing the position of the facial muscles and nerves. Unfortunately copyright does not allow me to reproduce it. This site is definitely worth a visit if you are looking for ways of improving your facial movement.

PHONE PALS

Some of you may remember Ella writing about the Phone Pals service run by Brain Tumour UK. We are thinking of setting up a similar group if members are interested. The groups would be of about six people and would meet through a telephone link on a regular basis. It would give the opportunity to talk with people dealing with similar issues. It may be particularly helpful for people with ongoing problems following surgery, trying to make a decision about what treatment to have or those on the 'watch and wait programme', particularly those who find it difficult to get to meetings. If you are interested in joining a group like this please contact Chris (01954 211300) or Alison (01953 860692).

Editorial

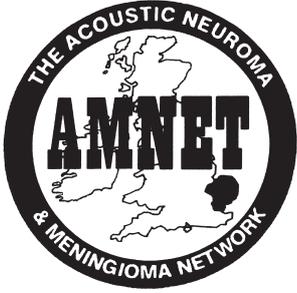
Dear All

Welcome to our summer edition of AMNET News. We have some interesting articles for you including the excellent talk given about radiotherapy treatment for acoustic neuromas and meningiomas to us by Kate Burton at the last meeting. There is also an article from Steve West a new member relating his decision about treatment for his acoustic neuroma. I would also remind you about the BANA AGM which we are hosting on July 8th. It would be great to see as many as possible of our members there – you do not have to be a member of BANA to come. If you do want to come please let Alison or myself know so we can have some idea about numbers.

As I am sure many of you are aware there are a growing number of people in the 'watch and wait' scheme whereby their acoustic neuromas are monitored regularly using MRI scans and treatment is only carried out if the tumour is becoming too large. I would be very interested in any information or experience of members who are in this situation or have been in this situation. The committee feels that the organization should be offering more to help this group of people and I would like to include some information and records of people's experience in the Winter newsletter.

Best wishes

Chris.



Annual General Meeting Of the British Acoustic Neuroma Association

To be held on Saturday 8th July 2006.
Addenbrookes Hospital in Cambridge

To start at 11.00 hrs – 15.30hrs
(Coffee and Registration from 10.30)

Following official business there will be presentations by

Mr Patrick Axon FRCS

Consultant Neurotologist at Addenbrookes Hospital

Mrs Chris Richards

talking about research carried out with members of AMNET

Ms Clare Sims

Superintendent Radiographer at Addenbrookes Hospital plus a
member of the Oncology team at Addenbrookes Hospital.

All BANA members and AMNET members are welcome. Please complete the slip below if you would like to come which would help us with catering arrangements. Further information from BANA Head Office on 01623 632143 or 0800 6523143



I/we will be attending the BANA AGM on Saturday July 8th at Addenbrookes Hospital, Cambridge

Name/s _____

Please return to: Alison Frank, Old School House, The Green, Old Buckenham, NR17 1RR

Please think about writing something for your newsletter. It can be anything you feel will be of interest to members.

Anything from a few lines to a couple of pages

It all helps to make the newsletter more interesting.

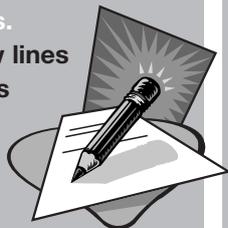
Contributions on paper and/or disc (Microsoft Word) to:-

Chris Richards

**12 Sudeley Grove, Hardwick
CAMBRIDGE CB3 7XS**

email: chris@richards2113.fsnet.co.uk

by: 30th September 2006



Next time you go surfing don't forget our AMNET web-page on <http://www.ii-group.com/amnet>

If you want to suggest any contents please let us know.

Addresses and Web sites

Addenbrooke's new website
www.addenbrooke's.org.uk

Changing Faces

(Registered Charity 1011222)

The Squire Centre,
33-37 University Street,
London WC1E 6JN

Switchboard Number: 0845 4500 275

Email: info@changingfaces.org.uk

Website <http://www.changingfaces.org.uk>

Changing Faces acts as a resource for the empowerment of people with facial distinctions. Free information packs and booklets are available.

RNID Tinnitus Helpline

(Registered Charity 207720)

Castle Cavendish Works,
Norton Street,
Nottingham NG7 5PN

Surfing the Net?



Tel/Textphone 0115 942 1520

For further information:

Email: tinnitushelpline@binternet.com

Website: <http://www.rnid.org.uk>

The British Tinnitus Association (BTA)
4th floor, White Building, Fitzalan
Square, Sheffield S1 2AZ

Freephone enquiry line 0800 018 0527

Web site: <http://www.tinnitus.org.uk/>

Hearing Concern

7-11 Armstrong Road, London W3 7JL

Help Desk 0845 0744b 600

Email: info@hearingconcern.org.uk

Web site: <http://www.hearingconcern.org.uk>

AMNET Advisory Panel at Addenbrooke's Hospital

Mr David Baguley MSc MBA
Principal Audiological Scientist

Jean Hatchell

Clinical Nurse Practitioner

Mr Robert Macfarlane MD FRCS
Consultant Neurosurgeon

Mr David Moffat BSc MA FRCS
Consultant in Otoneurological and
Skull Base Surgery

Mr N J C Sarkies MRCP FRCS
FRCOphth Consultant Ophthalmic Surgeon

The Meningioma Association UK

**53 Pine Grove,
Brookman's Park,
Herts AL9 7BL**

Tel: 01787 374084

Email: MeningiomaUK@aol.com

Website: www.meningiomaUK.org

BANA has produced some new booklets which may be of interest:-

A Basic Overview of Diagnosis and Treatment of Acoustic Neuroma

The Facial Nerve and Acoustic Neuroma

Headache after Acoustic Neuroma Surgery

Eye care after Acoustic Neuroma Surgery

Balance following Acoustic Neuroma

All these booklets are available from Alison. There is a charge of £2.00 for all except for the first title.

Facial Stimulators

AMNET has some Facial Trophic Stimulators which are available to members for short term loan. There is a charge of £25 at present which includes maintenance and postage. If you would like to know more please contact: **Margaret Allcock on 01493 700256**

BANA

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Oak House, Ransomwood Park
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Mansfield, Notts NG21 0HJ**

Tel: 01623 632143 Fax: 01623 635313

Freephone: 0800 652 3143

Email: bana@ukan.freeseve.co.uk

New Website: www.bana-uk.com

FORTHCOMING MEETINGS

DATES for your DIARY in 2006

Saturday 8th July 2006

BANA AGM in conjunction with AMNET meeting at **Addenbrookes Hospital**
See details inside (page 7)

Saturday 16th September 2006

AMNET AGM and 10 year anniversary at Addenbrookes Hospital
Speaker will be **Mr N Sarkies MRCP FRCS Consultant Ophthalmic Surgeon**

Saturday 25th November 2006

AMNET Christmas meeting at Addenbrookes Hospital
Speaker to be arranged

A Necessary Note

AMNET News is very appreciative of the opportunity to publish items relevant to the interests of acoustic neuroma and meningioma patients. This includes instances where members of AMNET have experienced relief, improvement, difficulties or otherwise and write to us of their experiences in order to pass on information for the interest and possible benefit of other members. However, AMNET cannot endorse proprietary products or be held responsible for any errors, omissions or consequences resulting from the contents of this Newsletter.

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